Evidence For The change of Name shown on G114 12/02/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

81a

11106

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs. 5 mos. 14 das.

Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.

How long in hospital or institution? 26 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: South Carolina County: Orangeburg

City or town: Orangeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME

FRANCIS D. ~~BAKER~~ BATES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 29, 1893

8. AGE: Years	Months	Days	If less than one day
54	3	6	hrs. min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Insurance Salesman

11. Industry or business

FATHER
12. Name: Deceased
13. Birthplace: Deceased

MOTHER
14. Maiden name: Deceased
15. Birthplace

16. Informant: Hospital Records

Address: VAH, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 12-15-47 (month) (day) (year)

Cemetery or crematory: Sunnyside Cemetery

Location: Orangeburg, South Carolina

18. Funeral director: Cunningham & Son

Address: Havre de Grace, Maryland

19. Dec 15 1947 Irma E. Dougherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1947 at 8:15AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 21 1933 to Dec. 15 1947 and that I last saw him alive on Dec. 15 1947

Immediate cause of death	DURATION
Pneumonia, bronchial	72 hrs.
Due to: Meningitis, serous	Unkn.
Due to:	
Other conditions: Tuberculosis, pulmonary	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Lobotomy, frontal, bilateral — Date of op.

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of — —

Where did injury occur? — — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) — —

Means of injury — — Injured at work? — —

23. SIGNATURE: A. E. Trollinger
A. E. TROLLINGER, M.D., Clin. Director
Address: VAH, Perry Point, Md. Date signed: 12-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11107

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, Institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution? Around 1½ years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: North Carolina County: Henderson

City or town: Hendersonville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: General Delivery

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME: ROBERT EDWARD BOURGET

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: --

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 9-5-18

8. AGE:

Years	Months	Days	If less than one day
29	3	15	....hrs. ....min.

9. Birthplace: New York, N. Y. (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER

12. Name: William A. Bourget

13. Birthplace: Unknown

MOTHER

14. Maiden name: Eleanor L. Krouse

15. Birthplace: New Haven, Conn.

16. Informant: Hospital Records

Address: Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 12/23/47 (month) (day) (year)

Cemetery or crematory: Arlington Nat'l Cemetery

Location: Ft. Meyer, Virginia

18. Funeral director: Runnigstad Bros

Address: Havre de Grace, Md.

19: Dec. 23 19 47 (Date rec'd by registrar) Irma E. Dunnigstad (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20 19 47 at 11:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10 19 47 to Dec. 20 19 47 and that I last saw him alive on Dec. 10 19 47

Immediate cause of death	DURATION
Pneumonia, bronchial, bilateral	4-5 days
Due to: Hodgkins Disease	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.: --

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work? --

23. SIGNATURE: A. E. TROLLINGER, M.D., Clin. Director (M. D. or other)

Address: VAH, Perry Point, Md. Date signed: 12-22-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

120b 11108

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton — (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Entire 2 Days.
Hospital, Institution, or street address where death occurred: Union Hosp
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East (If outside city or town limits, write RURAL and give nearest town)
Street No. R 40 2 (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Otis Lee Brickley (Brickley)

3.(b) Social Security Number: 221-09-6801

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna A. Brickley
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 9 1879

8. AGE: Years 68 | Months 7 | Days 22 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Rising Sun R.D. Md (town, county, and state)
10. Usual occupation: Storekeeper
11. Industry or business:
FATHER 12. Name: J Franklin Brickley
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Annan
15. Birthplace: Maryland
16. Informant: Mrs Otis Brickley
Address: North East, R.D #2
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 5 1947 (month) (day) (year)
Cemetery or crematory: Elkmanger Cemetery
Location: Rising Sun Rural
18. Funeral director: Joseph R. Grant
Address: North East, Md.
19. Dec 4 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 — 1947 at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 6, 1947, to Dec 2, 1947 and that I last saw h— alive on Dec 1, 1947

	DURATION
Immediate cause of death: —	
Carcinoma Pancreas Metastasis	3 days
Due to: Intestinal Obstruction	
Due to: Generalized Arteriosclerosis	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Intestinal adhesions + obstruction Date of op. Nov 15/47
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: H. A. Cantwell M.D. M. D. or other
Address: North East, Md. Date signed Dec 3/47

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11109

56a

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton - Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Union Hosp.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: North East Md RD 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ada Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: David Brown

6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): Unknown 1875

8. AGE: Years: 72 Months: Days: If less than one day: hrs. min.

9. Birthplace: Edenton - N.C.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Ind. Brown

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Sappie Mills

15. Birthplace: Unknown

16. Informant: Hosp Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-7-47 (month) (day) (year)

Cemetery or crematory: Baptist

Location: North East Md

18. Funeral director: Joseph R Grant

Address: North East Md

19. Dec 6 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 19 47 at 11.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 27 1947 to Dec 2 1947 and that I last saw h[illegible] alive on Dec 2 - 1947

Immediate cause of death	DURATION
Hemorrhage from a ruptured Esophageal varicose	10 days
Due to Arteriosclerosis	
Due to	
Other conditions Large ovarian cyst of left side	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. H. McKnight M.D. M. D. or other

Address: Elkton - Md Date signed: 12/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a

Reg. Diat. No. 11110/2

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 days
Hospital, Institution, or street address where death occurred: Union Hospital Elkton
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: North East R D # 2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME David Brown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Widowed

6.(b) Name of ~~husband~~ or wife: Ada Brown
6.(c) If alive, give age: — years
7. Birth date of deceased (mo., day, yr.): ~~Unknown 72 yrs old~~ 12-2-47

8. AGE: Years: 83 | Months: X | Days: X | If less than one day: — hrs. — min.

9. Birthplace: Portsmouth Va.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-7-47 (month) (day) (year)
Cemetery or crematory: Baptist
Location: North East Md
18. Funeral director: Joseph R. Grant
Address: North East Md
19. Dec 6 1947 (Date rec'd by registrar) H R Fraser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 December 1947, at 5 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Nov 1947 to 6 Dec 1947 and that I last saw h. I/m. alive on 5 December 1947

Immediate cause of death	DURATION
Cerebral accident -	
Due to: Arteriosclerosis	
Due to: Complete mental breakdown	
Other conditions: Spastic paraplegia	
Malnutrition	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: Grant
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George J Knein Jr M. D. or other
Address: Elkton Md Date signed: 6 Dec 47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1600a

11111

Reg. Dist. No. 97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred: Union Hosp.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 199 Hollingsworth Manor

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Patsy Baby Chadwick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 25 1947

8. AGE: Years | Months | Days: 6 | If less than one day: hrs. min.

9. Birthplace: Elkton - Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER 12. Name: Howard Chadwick

13. Birthplace: Warwick - Md

MOTHER 14. Maiden name: Edith Crain

15. Birthplace: Bason, W. Va

16. Informant: Howard Chadwick

Address: 199 Hollingsworth manor Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1-5-48 (month) (day) (year)

Cemetery or crematory: Forest Lawn

Location: Middletown

18. Funeral director: J. Luther Daniels

Address: Townsend Delaware

19. Jan 5 1948 (Date rec'd by registrar) F K Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1947, at 2.10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26th 1947 to Dec 31 - 1947 and that I last saw h.. alive on Dec 31 - 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: Birth - with convulsions	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: T. H. McKnight Jr. M. D. or other

Address: Elkton - Md Date signed: 12/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11112

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Cecil
City or town: Port Deposit
(If outside city or town limits, write RURAL and give nearest town)
Street No.: S. Main
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jane Emery Cropper

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Cropper
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 3, 1854

8. AGE: Years	Months	Days	If less than one day
93	10	11	hrs. min.

9. Birthplace: Scotland
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: William Emery
13. Birthplace: Scotland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Scotland

16. Informant: Margaret Abrahams
Address: Port Deposit, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 17, 1947 (month) (day) (year)
Cemetery or crematory: Hopewell
Location: Port Deposit, Md. Rural
18. Funeral director: Lewis Patterson & Son.
Address: Perryville, Md.

19. Dec. 17 1947 Irma E. Daugherty
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1947 at 3:14 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 1947 to Dec-14 1947 and that I last saw her alive on Dec-14-1947

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. J. Benson, M. D.
M. D. or other
Address: Port Deposit Md. Date signed 12/16/47.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11113

468

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton R.D. #3
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Elkton Md R.D. #3
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME George W. Curry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	(widowed)

6.(b) Name of husband or wife: Nellie J. Curry

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 4, 1864

8. AGE: Years	Months	Days	If less than one day
83	2	12	..... hrs. ..... min.

9. Birthplace: Scotland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: George W. Curry

13. Birthplace: Scotland

MOTHER 14. Maiden name: Hattie Jones

15. Birthplace: Scotland

16. Informant: John J. Curry

Address: Elkton Md R.D. #3

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 17 1947 (month) (day) (year)

Cemetery or crematory: Elkton

Location: Elkton Md.

18. Funeral director: H. W. Pippin & Son

Address: Elkton Md.

19. Dec 17 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 1947 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 1947 to December 13 1947 and that I last saw him alive on December 12, 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	5 months
Due to	
Due to	
Due to	
Other conditions: Secondary Carcinoma	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James L. Johnson M.D.
M. D. or other

Address: 226 E. High St., Elkton Md Date signed: 12/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11114

CERTIFICATE OF DEATH

Reg. Diat. No. 95

1. PLACE OF DEATH:

County Cecil

City or town Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residance of mother)

State Md. County Cecil

City or town Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Gertrude Dinsmore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife Wm. Dinsmore

6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) March 21 1874

8. AGE: Years 73 | Months 8 | Days 21 | If less than one day ... hrs. ... min.

9. Birthplace Rising Sun Md. (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business

FATHER 12. Name Wm. Thomas Johnson

13. Birthplace Rising Sun Md.

MOTHER 14. Maiden name Rachael Kirk

15. Birthplace Rising Sun Md.

16. Informant Wm. Dinsmore

Address Rising Sun Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Dec. 15. 1947 (month) (day) (year)

Cemetery or crematory Evergreen

Location Near Rising Sun. Md.

18. Funeral director J. E. Tyson

Address Rising Sun. Md.

19. Dec 12 19 47 L M Mottington (Signature of local registrar)

Certificate received 12-13-47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 19 47 at 10.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death Coronary Arteriosclerosis

Due to Rheumatism

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ... Date of op. ...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

12 SIGNATURE W. E. Dodson M.D. Medical Examiner Cecil County

M. D. or other

Address Rising Sun Md. Date signed 10/12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a

11115

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:
County: CECIL
City or town: PERRY POINT, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 4 mos. 1 da.
Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.
How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County: New Castle
City or town: Wilmington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 317 W. 28th Street
(If rurel, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: WILLIAM H. EDWARDS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): January 21, 1890

8. AGE: Years	Months	Days	If less than one day
57	10	10	..... hrs. ..... min.

9. Birthplace: Wilmington, Delaware
(Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: William H. Edwards, Sr.
13. Birthplace: Wilmington, Delaware

MOTHER
14. Maiden name: Sallie Barney
15. Birthplace: Wilmington, Delaware

16. Informant: Hospital Records
Address: VAH, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 12-1-47 (month) (day) (year)
Cemetery or crematory: Riverview Cemetery
Location: Wilmington, Delaware
18. Funeral director: Albert J. McCrery Jr. McCRERY FUNERAL HOME
Address: 2700 Washington St., Wilmington, Del.

19. Dec 1 1947 (Date rec'd by registrar) Irene E. Daughtry Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1947 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1944, to Dec. 1 1947 and that I last saw him alive on December 1 1947

Immediate cause of death	DURATION
Adenocarcinoma, kidney, left	Prob. over 1 year
Due to:	
Due to:	
Other conditions: Coronary arteriosclerosis	Unknown
Generalized arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: Confirms above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: Dr. Dodson MD Medical Examiner for Cecil County
M. D. or other
Address: Perry Point Md. Date signed: 12-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11116

93d

Reg. Diat. No. 95

1. PLACE OF DEATH:

County Cecil Co.

City or town Outside Rising Sun Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County Cecil Co Md.

City or town Outside Rising Sun Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph K. Fox

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 12 1871

8. AGE: Years 76 | Months 3 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Rising Sun Md.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name John alford Fox.

13. Birthplace Ford Pa.

MOTHER 14. Maiden name Caroline Peburn

15. Birthplace Offord Pa.

16. Informant Fred Fox

Address Rising Sun Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19, 1947 (month) (day) (year)

Cemetery or crematory Offord Pa.

Location Offord Pa.

18. Funeral director E. Tyson.

Address Rising Sun Md.

19. Dec 17 1947 (Date received by registrar) L M Mottinger Registrar

Permit issued 12-17-47

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1947 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945 to Dec 16 1947 and that I last saw him alive on 12-14 1947

Immediate cause of death: Chronic Myocarditis

Due to: with Hypertension

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

SIGNATURE R. L. Dodson M.D. M. D. or other

Address Rising Sun Md. Date signed 12/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11117

54a Bc

CERTIFICATE OF DEATH

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 days

Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 W. Mulberry Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: ALLAN T. GRANBURY

3. (b) Social Security Number: 214-03-2984

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): February 3, 1894

8. AGE: Years	Months	Days	If less than one day
53	10	6	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Guard

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: VAH, Perry Point, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 12-12-47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Pennington & Son

Address: Havre de Grace, Md.

19. Dec. 12 1947 (Date rec'd by registrar) Irene E. Dewhurst Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9th 1947 at 5:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 17th 1947, to Dec. 9th 1947 and that I last saw him alive on Dec. 9th 1947

Immediate cause of death	DURATION
Tumor of the brain - type, asprocytoma	Unknown
Due to: Bronchopneumonia	48 hrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury: ... Injured at work?

23. SIGNATURE: V. J. COVALESKY, M. D., Actg. Clin. Dir.

Address: VAH, Perry Point, Md. Date signed: 12-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d

11118

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 minutes

Hospital, institution, or street address where death occurred: Union Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: North East Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Fred. D Johnson.

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	Married

6.(b) Name of husband or wife: Mary Emma Johnson

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Aug 27 1871

8. AGE: Years	Months	Days	If less than one day
76	3	19	hrs. min.

9. Birthplace: Elk Neck Cecil Co Md (Town, county, and state)

10. Usual occupation: farm Laborer

11. Industry or business

FATHER — 12. Name: David F Johnson

13. Birthplace: North East Rural Md

MOTHER — 14. Maiden name: Ellen Robinson

15. Birthplace: North East Rural Md

16. Informant: Mrs Fred Johnson

Address: North East R D 2 Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 21 1947 (month) (day) (year)

Cemetery or crematory: St Marks A.M.P.

Location: North East R D # 2 Md

18. Funeral director: Joseph R Grant

Address: North East Md

19. Dec 19 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 16 1947 at 2.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemeplegia and	
Due to Pneumonia Bronchial.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner for Cecil County

Address: Rising Sun Md. Date signed: 12/16/47

M. D. or other

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11119

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 10

Reg. Diat. No. 95

1. PLACE OF DEATH:
County Cecil Co.
City or town Outside Rising Sun Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Cecil Co.
City or town Outside Rising Sun Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Leggie May Kirk

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife Cassius F. Kirk
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 10 1873

8. AGE: Years	Months	Days	If less than one day
74	11	6	..... hrs. ..... min.

9. Birthplace Rising Sun Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name George W. Gifford
13. Birthplace Bucks Co Pa.

MOTHER
14. Maiden name Catherine R. Keithley
15. Birthplace Md.

16. Informant John L. Gifford
Address Rising Sun Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20-47 (month) (day) (year)
Cemetery or crematory West Patapsco
Location Colora Md.

18. Funeral director J. E. Tyson
Address Rising Sun Md

19. Dec 17- 1947 L. M. Mortimer Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1947 at 12 45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1947 to Dec - 15 1947-
and that I last saw h.. alive on Dec 15 1947.

	DURATION
Immediate cause of death Chronic Endocarditis	10 Yrs
Due to	
Due to	
Other conditions Chronic Nephritis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE L. H. Brown, M. D.
M. D. or other
Address Port Deposit Md. Date signed 1/2/48

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 11120

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years.
Hospital, Institution, or street address where death occurred: West Main Street
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Phila.
City or town: Philadelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2010 Spring Garden.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Mary. Koerner.

3.(b) Social Security Number:

4. Sex: F
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Nicholas Koerner
6.(c) If alive, give age: ...years
7. Birth date of deceased (mo., day, yr.): April 2 1867

8. AGE: Years: 80 Months: 8. Days: If less than one day: ...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Adam Kraatel
13. Birthplace: Germany.
MOTHER 14. Maiden name: Younger
15. Birthplace: Germany
16. Informant: Frank J. Koerner
Address: 1007 Monroe St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 5-47 (month) (day) (year)
Cemetery or crematory: Cathedral
Location: Wilmington - Del
18. Funeral director: H. W. Popkin
Address: Elkton, Md.
19. Dec 4 19 47 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 19 47; at 3.20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...
and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death: Acute Coronary Disease.	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County
M. D. or other
Address: Elkton Md. Date signed: 12-8-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Letter Mail.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11121

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs. 6 mos. 11 days

Hospital, institution, or street address where death occurred:
VA Hospital, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Balto

City or town: Lansdowne
(If outside city or town limits, write RURAL and give nearest town)

Street No. 343 3rd Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: LEWIS, Harry N.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mrs. Zena Lewis

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 16, 1893

8. AGE: Years	Months	Days	If less than one day
54	1	7	____ hrs. ____ min.

9. Birthplace: Boston, Mass.
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business:

FATHER
12. Name: Thomas J. Lewis - deceased
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Fannie Taylor - deceased
15. Birthplace: Baltimore, Md.

16. Informant: Hospital Records
Address: VAH, Perry Point, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Wm. Cook Inc.
Address: St. Paul & Preston Sts., Baltimore, Md.

19. Dec. 24 1947 (Date rec'd by registrar) Irene Eskaylo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 1947 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1944 to Dec. 23, 1947 and that I last saw him alive on Dec. 23, 1947

Immediate cause of death	DURATION
Infarction, massive, of myocardium	48 hrs.
Due to: Embolism	48 hrs.
Due to: Coronary arteriosclerosis	
Other conditions: Syphilitic meningo-encephalitis	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -- Date of: ____

Where did injury occur? -- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) --

Means of injury -- Injured at work?

23. SIGNATURE: A.E. Trollinger
A.E. TROLLINGER, M.D., Clinical Director
M.D. or other
Address: VAH, Perry Point, Md. Date signed: 12-24-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11122

131a

Reg. Dist. No. 94

1. PLACE OF DEATH:

County: Cecil

City or town: northeast Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.: —

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Hilda Leivonen

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Otto Leivonen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 6 1859

8. AGE:

Years	Months	Days	If less than one day
88	8	18	..... hrs. ..... min.

9. Birthplace: Iyvaskyla F inland

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: Salonen

13. Birthplace: F inland

MOTHER

14. Maiden name: no information

15. Birthplace

16. Informant: Hilma Jeanstrom

Address: north East RD 2 md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-27-47 (month) (day) (year)

Cemetery or crematory: Methodist

Location: north East Md

18. Funeral director: Joseph R. Evans

Address: north East Md

19. 12-27 19.47 (Date rec'd by registrar) Lyda V. Evans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 Dec 19.47, at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19.47, to 24 Dec 19.47

and that I last saw her alive on 23 Dec 19.47

Immediate cause of death	DURATION
Uremia	8 days
due to Nephrosclerosis, benign	
Due to Hypertensive Cardiovascular Disease	
Conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — — — (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Klaus H Teuchner M.D.

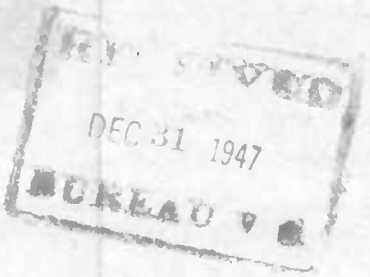
M. D. or other

Address: North East, Md. Date signed: 26 Dec 47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


DEC 31 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11123

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

County: CECIL

City or town: PERRY POINT, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 12 days

Hospital, institution, or street address where death occurred:
VAH, Perry Point, Md.

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: Worchester

City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-II

3.(a) FULL NAME

NORMAN L. MANUEL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Laura E. Manuel

6.(c) If alive, give age: Unkn. years

7. Birth date of deceased (mo., day, yr.): May 12, 1912

8. AGE: Years	Months	Days	If less than one day
35	7	8	...hrs. ...min.

9. Birthplace: Stockton, Maryland
(Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Perry Point, Md.

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof: 12-22-47
(month) (day) (year)

Cemetery or crematory: Home Beneficial Cemetery

Location: Stockton, Maryland

18. Funeral director: Pennington & Son

Address: Havre de Grace, Maryland

19. Dec. 22 1947 Irma E. Daughtry
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20 1947, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8 1947, to Dec. 20 1947 and that I last saw him alive on Dec. 20 1947

Immediate cause of death	DURATION
Pneumonia, bronchial, right	4-5 days
Due to: Hypertensive cardio-vascular renal disease	Unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: ——

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of: ——

Where did injury occur? —
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ——

Means of injury: Injured at work? ——

23. SIGNATURE: A. E. TROLLINGER, M.D., Clin. Director
M. D. or other

Address: VAH, Perry Point, Md. Date signed: 12-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH LASTING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11124

940

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH

County Cecil

City or town Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Cecil

City or town Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Parker J. Moran.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Married

6.(b) Name of husband or wife: Annie E. Moran

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) March 10 1876

8. AGE: Years 71 Months Days 25 If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name James Moran.

13. Birthplace Baltimore Md.

MOTHER 14. Maiden name Marie Miller

15. Birthplace Maryland.

16. Informant Mrs Annie Moran.

Address Rising Sun Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12/9/47 (month) (day) (year)

Cemetery or crematory Western

Location Balto

18. Funeral director L. J. Kuck

Address 5305 Harford Road

19. 12 15 19 47 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Acute Coronary disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Dodson M.D. Medical Examiner for Cecil County

M. D. or other

Address Rising Sun Md. Date signed 12-5-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d

RC 11125

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Perryville, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 834 Power St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Sarah Elizabeth Morris

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Nathan Morris

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 22, 1864

8. AGE: Years	Months	Days	If less than one day
83	2	16	hrs. min.

9. Birthplace: Gorsuch Mills, Balto. Co., Md
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER
12. Name: Samuel Billingsly
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden name: Sarah Stabler
15. Birthplace: Balto., Co., Md

16. Informant: Lewis Morris
Address: Linthicum Heights, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 10, 1947 (month) (day) (year)

Cemetery or crematory: Friendship Cemetery

Location: Linthicum Heights, Anne Arundel Co., Md.

18. Funeral director: Lewis A. Patterson & Son

Address: Perryville, Md.

19. Dec. 10 1947 Irene E. Daugherty Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8 1947, at 7 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16th 1947, to Dec. 8 1947 and that I last saw h.. alive on Dec. 7 1947

Immediate cause of death	DURATION
Cerebral Haemorrhage	4 da.
Due to	
Due to	
Other conditions: Chronic Valvular Heart Disease	15 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. F. Magraw M. D. or other

Address: Perryville Md. Date signed 12/8/1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Evidence for change of cemetery and location and addition of funeral directory & address shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11126

94a

FILM No. G 114 MAR 15 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 94

1. PLACE OF DEATH:

County Cecil

City or town North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Died

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del. County New Castle

City or town Newark Rural.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jane McCoy Moss.

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 25 1902.

8. AGE:

Years	Months	Days	If less than one day
45	1	12.	hrs. ... min.

9. Birthplace Newark. Del.
(Town, county, and state)

10. Usual occupation Lumber Business

11. Industry or business

FATHER

12. Name John H. Moss.

13. Birthplace Mechanicsville, Del.

MOTHER

14. Maiden name Mary M. McCoy.

15. Birthplace Middletown Del.

GLASGOW

16. Informant Mary R Moss.

Address Newark R.D.I Del.

17. Burial Date thereof Dec 11 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenville. Bethel

Location NR. CHESAPEAKE CITY MD. Methodist Church

18. Funeral director Joseph R. Robert & Jones Grant

Address North Eas. Md - Newark, Del.

19. 12-9-1947 Lida L. Evans
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1947, at 330 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Coronary Disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. Signature R. E. Dodson M.D. (Medical Examiner for Cecil County)
M. D. or other

Address Rising Sun Md Date signed 12-7-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11127

CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs - 11 days

Hospital, institution, or street address where death occurred:
Veterans Administration

How long in hospital or institution? Same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Perry Point, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American War

3.(a) FULL NAME: MURPHY, Anthony

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: ///// Unknown - deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1864

8. AGE: Years	Months	Days	If less than one day
83	1	18	..... hrs. ..... min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Railroad Worker

11. Industry or business

FATHER
12. Name: Unknown - deceased
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown - deceased
15. Birthplace: Unknown

16. Informant: Hospital records
Address: VAH, Perry Point, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-5-48 (month) (day) (year)

Cemetery or crematory: ////// Baltimore National Cemetery, Md.

Location: Baltimore, Maryland

18. Funeral director: Pennington & Son
Address: PENNINGTON & SON, Havre de Grace, Md.

19. Jan. 5 1948 (Date rec'd by registrar) Irene E. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29, 1947, at 7:25P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18, 1941, to Dec. 29 1947 and that I last saw him alive on December 29, 1947

Immediate cause of death	DURATION
Arteriosclerosis, generalized	Over 30 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: ——

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: —— Date of

Where did injury occur? —— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ——

Means of injury: — Injured at work?

23. SIGNATURE: V. J. COVALESKY, M.D., Actg. Clinical Director

Address: VAH, Perry Point, Md. Date signed 1-5-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11128

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, Institution, or street address where death occurred: 15 Grove.
How long in hospital or institution? Union Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Elkton Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Edith Louise Onigunk

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife: Samuel Onigunk
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): Dec. 17. 1919.

8. AGE: Years 27 | Months 11 | Days 15 | If less than one day: hrs. min.

9. Birthplace: Elkton Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Daniel Butler
13. Birthplace: Elkton Md.

MOTHER
14. Maiden name: Mary E Conner.
15. Birthplace: Principio Md.

16. Informant: Samuel Onigunk
Address: Elkton R D 3 Md

17. Burial. Date thereof: Dec. 6, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Catholic
Location: Elkton, Md

18. Funeral director: H W Lippin
Address: Elkton, Md

19. Dec 5 1947 F R Frazer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1947 at 9:12 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
2 & 3rd degree burn of Venture	
Due to: body	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 12-2-47
Where did injury occur? Elkton Cecil Md
(City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) Home.
Means of injury: Explosion of Stove Injured at work?

23. SIGNATURE: R L E Dodson M.D. Medical Examiner for Cecil County
Address: Elkton Md. M. D. or other
Date signed: 12-3-47

VS/A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

11129

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:
County: Cecil
City or town: Cherry Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? deceased
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil
City or town: Cherry Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lewis A Peterson

3.(b) Social Security Number 220-18-2697

4. Sex: M
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie Mae Peterson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 19 1896
8. AGE: Years: 51 Months: 8 Days: 2 If less than one day: hrs. min.
9. Birthplace: Fair Hill, Md. (Town, county, and state)
10. Usual occupation: State Roads
11. Industry or business
FATHER 12. Name: John Peterson
FATHER 13. Birthplace: Fair Hill, Md.
MOTHER 14. Maiden name: Jane Drummond
MOTHER 15. Birthplace: Cherry Hill, Md.
16. Informant: Annie M. Peterson
Address: Elkton, Md. R.D. #5
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23, 1947 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Cherry Hill, Md.
18. Funeral director: H. W. Pippin & Son Per W. B. Pusey
Address: Elkton, Md.
19. Dec 22 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21 1947, at 3 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....
Immediate cause of death: A Coronary Occlusion
Due to: Arterio Sclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Dodson M.D. Medical Examiner Cecil County
Address: Rising Sun Md. M. D. or other
Date signed: 12-21-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11130

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 96

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton Rural.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Traveling through

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Aiken
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Charles H. Reckefus

3. (b) Social Security Number:

4. Sex: M.

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary M. Reckefus

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 8 1877

8. AGE: Years: 70 Months: 4 Days: 4 If less than one day: ..... hrs. ..... min.

9. Birthplace: Elkton Md.
(Town, county, and state)

10. Usual occupation: Asst. Registrar

11. Industry or business: Private School

MOTHER FATHER

12. Name: Wm. H. Reckefus

13. Birthplace: Philadelphia Pa.

14. Maiden name: Alice Mary Lyon

15. Birthplace: Port Deposit Md

16. Informant: Mrs. Mary M. Reckefus

Address: Perryville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15, 1947. (month) (day) (year)

Cemetery or crematory: West Nottingham

Location: Colora, Md. (Rural)

18. Funeral director: Lee A. Patterson & Son

Address: Perryville, Md.

19. Dec. 13 19 47 (Date rec'd by registrar) Irene E. Dawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 19 47 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Acute Pneumonia	
Due to: Pleurisy	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P. L. Dodson M.D. Medical Examiner Cecil County

Address: Rising Sun Md. Date signed: 12-12-47

M. D. or other

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316 11131

CERTIFICATE OF DEATH

Reg. Dist. No. 9r

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Cecil
City or town Elkton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Union Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Cecil
City or town Elkton Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Reynolds Charles C. Reynolds

3. (b) Social Security Number 220-26-3854

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Mary Reynolds
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Feb 23 1888

8. AGE: Years	Months	Days	If less than one day hrs.	min.
59	9	9		

9. Birthplace Elgnar Pennsylvania
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Joseph Reynolds
13. Birthplace Penna
MOTHER 14. Maiden name Elizabeth Walker
15. Birthplace Penna
16. Informant Mrs C Charles C Reynolds
Address Elkton RD 5 Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 15 1947 (month) (day) (year)
Cemetery or crematory Brookview
Location Rising Sun Md
18. Funeral director Joseph R. Lauer
Address North East Md
19. Dec 13 1947 (Date rec'd by registrar) F H Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 December 1947 at 7.57 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1947 to 11 Dec 1947
and that I last saw h[illegible] alive on 11 Dec 1947

	DURATION
Immediate cause of death Uraemia	5 days
Due to Pyelonephritis	Unknown
Chronic glomerular nephritis	Unknown
Due to Hypertrophy of Prostate	Unknown
Due to Hypertensive Cardiovascular Disease	Unknown
Other conditions Edema Uremia	5 days
Aortic insufficiency	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George J Krein Jr M. D. or other
Address Elkton, Md. Date signed 11 Dec 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11132

Reg. Diat. No. 96

1. PLACE OF DEATH:

County: Cecil

City or town: Port Deposit

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Connecticut County: New Haven

City or town: Waterbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Joseph Ryan

3.(b) Social Security Number: 041-16-0713

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Catherine C. Ryan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8, 1874

8. AGE: Years	Months	Days	If less than one day
71	6	25	..... hrs. ..... min.

9. Birthplace: Westville, Conn.

(Town, county, and state)

10. Usual occupation: Meat Cutter

11. Industry or business: Retail Store

FATHER — 12. Name: Morris Ryan

FATHER — 13. Birthplace: New London, Conn.

MOTHER — 14. Maiden name: Mary Margaret Heffernan

MOTHER — 15. Birthplace: Ireland

16. Informant: Hubert R. Ryan

Address: Port Deposit, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1947 (month) (day) (year)

Cemetery or crematory: Old St. Joseph

Location: Waterbury, New Haven Co., Conn.

18. Funeral director: Wm A. Patterson & Son

Address: Perryville, Md.

19 Dec. 4 19 47 Irma E. Dougherty Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION 47

20. DATE OF DEATH: December 3 1947 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10 19 47 to Dec 3 - 19 47

and that I last saw h.. alive on Dec - 3 - 19 47

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs
Due to	
Due to	
Arterio Sclerosis	8 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. J. Benson M. D.

M. D. or other

Address: Port Deposit Md Date signed 12/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

461 11133

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:
County: Cecil
City or town: Elkton, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
254 W. Main St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Cecil.
City or town: Elkton
(If outside city or town limits, write RURAL and give nearest town)
Street No. 254 W. Main
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Laura V. Simmons

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Wh.	Widowed

6.(b) Name of husband or wife: Joel T. Simmons
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 26, 1891

8. AGE: Years	Months	Days	If less than one day
56	4	4	..... hrs. ..... min.

9. Birthplace: Cecil Co. Md
(Town, county, and state)
10. Usual occupation: at Home
11. Industry or business

FATHER	12. Name	Philip R. Rothwell
	13. Birthplace	Cecil Co. Md
MOTHER	14. Maiden name	Alice Davis
	15. Birthplace	Cecil Co. Md

16. Informant: Ella May Rothwell
Address: Elkton, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2, 1948 (month) (day) (year)
Cemetery or crematory: Elkton
Location: Elkton, Md
18. Funeral director: H. Tippin
Address: Elkton, Md
19. Jan 2 19 48 (Date rec'd by registrar) F R Frazer (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30 19 47 at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 47 to Dec 30 19 47 and that I last saw h.... alive on Dec 29 19 47

	DURATION
Immediate cause of death: Carcinoma of stomach	1 Year
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Herbert Bates, M.D.
M. D. or other
Address: Elkton Md Date signed 12/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

8-a

11134

CERTIFICATE OF DEATH

Reg. Diat. No. 96

W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Cecil

City or town: Perry Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 4 mos. 29 days

Hospital, Institution, or street address where death occurred:
VA Hospital, Perry Point, Md.

How long in hospital or institution? 5 yrs. 4 mos. 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Alleghany

City or town: Pittsburgh
(If outside city or town limits, write RURAL and give nearest town)

Street No. 307½ Minton Street- Sheridan
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-II

3.(a) FULL NAME: STAMCHECK, Joseph F.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 19, 1911

8. AGE: Years	Months	Days	If less than one day
35	11	22	..... hrs. ..... min.

9. Birthplace: United States
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Stephen Stamcheck

FATHER — 13. Birthplace: Czechoslovakia

MOTHER — 14. Maiden name: Anna Schelski

MOTHER — 15. Birthplace: Czechoslovakia

16. Informant: Hospital Records

Address

17. Removal (Burial, cremation, or removal. Which?) Date thereof Dec. 12, 1947 (month) (day) (year)

Cemetery or crematory: Unknown

Location: McKees Rocks, Pa.

18. Funeral director: Lee A. Patterson & Son
LEE A. PATTERSON & SON

Address: Perryville, Md.

19. Dec. 12 19 47 (Date rec'd by registrar) Irene E. Humphreys Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11, 1947 at 9:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attendad deceased from July 12, 1943 to December 11, 1947 and that I last saw h im alive on December 11, 1947

Immediate cause of death	DURATION
Post-operative lobotomy	Operated
Due to: Post-operative aseptic meningitis	11-20-47
Due to: Post-operative uremia	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. .....

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of .....

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: V. J. COVALESKY, M.D., Actg. Clin. Director
V.J. COVALESKY, M.D., Actg. Clin. Director

Address: VAH, Perry Point, Md. Date signed: 12-12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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11135

CERTIFICATE OF DEATH

Reg. Diat. No. 92

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 hrs + 5 min.

Hospital, Institution, or street address where death occurred:

Union Hospital Cecil Co.

How long in hospital or institution? 2 hrs 5 mins

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Elkton, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 140 Wesley Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: [illegible]

3.(a) FULL NAME: Veasey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec 2, 1947

8. AGE: Years | Months | Days | If less than one day: 2 hrs. 5 min.

9. Birthplace: Union Hospital (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER — 12. Name: Allen Wilson Veasey

13. Birthplace: Elkton, Maryland

MOTHER — 14. Maiden name: Nellie Ewell Abel

15. Birthplace: Chesapeake City, Md.

16. Informant: Nellie Abel Veasey mother

Address: Elkton, Md.

17. Bur. (Burial, cremation, or removal. Which?) Date thereof: Dec 3 1947 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Chesapeake City R.D.

18. Funeral director: H. W. Pippin

Address: Elkton Md

19. Dec 3 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1947, at 1:45 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 1947, to Dec 2 1947

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Prematurity	6 mos.
Due to: Premature rupture of membranes - Spontaneous	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. Lemuel Downes M. D. or other

Address: Chesapeake City Md. Date signed: 12/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

11136

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days.

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Cecil

City or town: Rising Sun

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Rev. Frank White

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary White

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Aug. 20, 1876.

8. AGE:

Years	Months	Days	If less than one day
71	4	7	hrs. min.

9. Birthplace: Wilmington Del.
(Town, county, and state)

10. Usual occupation: Retired Minister

11. Industry or business

FATHER

12. Name: John White

13. Birthplace: Marysville Pa.

MOTHER

14. Maiden name: Loriba Proudfoot

15. Birthplace: Pa.

16. Informant: Mrs. Mary White

Address: Rising Sun. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 30, 1947 (month) (day) (year)

Cemetery or crematory: Lombardy Cemetery

Location: Wilmington. Del.

18. Funeral director: J. E. Ingoon

Address: Rising Sun. Md.

19. Dec 28 1947 (Date rec'd by registrar) F R Frazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13 1947 to Dec 27 1947

and that I last saw him alive on Dec. 26 1947

Immediate cause of death	DURATION
Left Ventricular Failure.	
Due to	
Arterio sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F C Dodson MD M. D. or other

Address: Rising Sun Md Date signed: 12-27-47

11137

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 95

1. PLACE OF DEATH:

County Cecil

City or town Rising Sun.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Cecil

City or town Rising Sun Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gertrude Emma Whitley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife Wm. H. Whitley

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Feb 3 1876

8. AGE:

Years	Months	Days	If less than one day
71	10		hrs. min.

9. Birthplace Honaker Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Melvin Burnett

13. Birthplace Honaker Va.

MOTHER 14. Maiden name Virginia Fletcher

15. Birthplace Honaker Va.

16. Informant Wm. H. Whitley

Address Rising Sun Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 6 1947 (month) (day) (year)

Cemetery or crematory Friends Burial Ground

Location at Calvert, Md.

18. Funeral director J. E. Tyson.

Address Rising Sun Md.

19. Dec 5 - 47 L. M. Worthington
Filed Dec 5 - 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1947, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Acute Coronary Disease.

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. L. Dodson M.D. Medical Examiner for Cecil County
M. D. or other

Address Rising Sun Md. Date signed 12/3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 a

11138

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH

County: Cecil

City or town: Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days.

Hospital, institution, or street address where death occurred: Union Hospital Elkton Md

How long in hospital or institution? 14 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Cecil

City or town: Zion

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Clinton J. Yerkes.

3. (b) Social Security Number

4. Sex: M.

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Jennie F. Yerkes.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 5 1858.

8. AGE: Years: 89. Months: 4 Days: 13 If less than one day ..... hrs. ..... min.

9. Birthplace: Cecil Co Md.

(Town, county, and state)

10. Usual occupation: Retired Farmer.

11. Industry or business

FATHER 12. Name: Edward Yerkes.

13. Birthplace: Doylestown Pa.

MOTHER 14. Maiden name: Lucy Algard.

15. Birthplace: Oxford Pa.

16. Informant: Edward E Yerkes.

Address: Riverton N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-21-47 (month) (day) (year)

Cemetery or crematory: Rosedale.

Location: Calvert Cecil Co Md.

18. Funeral director: J E Tipton.

Address: Rising Sun Md.

19. Dec 20 1947 (Date rec'd by registrar) F R Brazer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18 1947 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1 1947 to 12-18 1947

and that I last saw him alive on 12-17 1947

Immediate cause of death	DURATION
Cerebro vascular hemiplegia	
Due to: & general arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P. H. Dodson M.D. M. D. or other

Address: Rising Sun Md Date signed 12/20-47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING